

**Remarks before the Senate Health Policy Committee
Expanding Health Insurance Coverage in Michigan:**

The Nature of the Spread

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My name is Dean Smith. By way of disclosure, I am a Professor of Health Management & Policy, Senior Associate Dean for Administration and Director of the Center for Value-Based Insurance Design at the University of Michigan School of Public Health. I am also a member of the Board of Directors of Molina Healthcare of Michigan, a Medicaid-focused HMO and Vice-President of the Board of Directors of the Michigan Public Health Institute. My research and practice over the past twenty years has focused on financial aspects of working with and working in the healthcare industry. I am pleased to appear before you today to offer comments on expanding health insurance coverage in Michigan. This is a timely and important topic, and I applaud the leadership of the Senate Health Policy Committee on holding this meeting.

We have before us a series of bills that aim to expand coverage options to a number of different segments of our population and take a variety of approaches on the benefits to be offered, the regulations on insurers to be modified and the means by which coverage options will be financed. For purposes of making efficient use of my time today, I am going to play to my strength as an economist and focus on financing.

At its core, insurance is a means of spreading the costs of uncertain and untoward events among a population. In regards to health care, insurance serves the risk spreading function – we try to get many people to pay something to avoid financial ruin to the few who are afflicted with serious illness.

But health is a complex issue. One person's serious musculoskeletal affliction is another's minor trick knee; one person seeks care, another shrugs, one physician orders an MRI another says take it easy. Annual Medicare costs per enrollee in

Traverse City in 2006 were \$6,611 and in Dearborn they were \$10,689. As written by Dr. Gawande in last week's New Yorker, local practice patterns defy simple explanations, but point to a problematic system of care that almost requires that persons have some form of insurance that is locally sensitive to benefits and costs.

As noted by many who care about the health of the Michigan population, a real concern is that so many persons lack health insurance coverage. Lack of health insurance coverage is associated with delayed and/or inappropriate use of health services and a spreading of their costs of medical services starting at the provider. Providers see uninsured patients and spread those costs among their insured patients. Spreading costs in this manner may not be viewed as equitable if uninsured patients cluster use among certain providers or if the care given to patients varies by insurance status – be it stemming from patient or provider behavior. One means of making the spreading of costs more equitable would be to expand programs like Medicare's Disproportionate Share payment adjustment. This fixes the equity aspect – but still leaves persons in an uninsured status that is associated with delayed and/or inappropriate use of health services.

Options for making insurance coverage more widely available are require two critical components. First the insurance option must be locally sensitive to benefits and costs. Insurance with inadequate benefit design or inadequate provider payment rates won't fix the right care at the right time problem and is no better a fix than a provider cost-spreading solution. Someone needs to think seriously about what benefits are covered and how providers will be paid. There are some philosophical issues here, and I would argue for a value-based insurance design, but compromises here should be relatively easy.

Second, the insurance option must be at a lower price than is currently charged – a premium subsidy. To the extent that insurance would otherwise be priced at actuarially fair values, reducing prices must involve spreading. For the portion of the price that would be paid by the consumer, there are again philosophical issues involved. Should

current smokers be asked to pay a higher price than non-smokers? Doing so will create an incentive for some persons to quit smoking, leading to improved health status and lower costs in the long-run, as well as make a statement about individual responsibility. In the short-run, a smoking premium will lead to fewer smokers electing insurance and hence more uncompensated costs to be spread among providers.

So, if the State offers programs with premium subsidies, how can we spread this cost?

I offer first a couple of numbers – which are approximate and perhaps outdated. We have something in the ballpark of 10 million persons in Michigan, of whom 5.5 million are covered in medium or large group plans and 1.8 million are covered by Medicare, Medicaid or both. Another 700 thousand persons are in the small group (2-50 lives) insurance market and 350 thousand persons have individual health insurance in Michigan. This leaves us with some 250 thousand persons with moderate or high incomes who elect not to purchase insurance and are not targeted by current legislation, 900 thousand persons with low incomes who are targeted and 50 thousand persons who are currently or potentially medically uninsurable.

The current mechanism for premium subsidies is to require Blue Cross Blue Shield of Michigan to accept persons deemed medically uninsurable by others in the role of insurer of last resort. The subsidy in the uninsurable market is held completely within BCBSM and is thought to be an offset against its favorable tax-exempt status. I have not participated in an analysis of BCBSM's profit or loss with this line of business, but would not be surprised to find that there is little room for pushing for expansion of this market segment as currently structured.

I am very worried about whether there's a good solution to this portion of the insurance problem. States that have created risk pools (requiring some or all insurers to take all applicants) or reinsurance mechanisms (when one or all insurers participate) have indeed increased the number of insured persons within this market segment, but at the expense of a larger number of uninsured persons in the individual and small group

insurance markets who paid for the risk pools and reinsurance. Increasing the number of medically uninsurable persons into with coverage at the expense of a larger number of other persons dropping coverage is a tough ethical trade-off.

Making a significant expansion of insurance coverage requires looking beyond just the medically uninsurable towards those low income persons who financially don't purchase health insurance.

Given the state of the State budget, there is no room for a general assessment to raise funds to subsidize health insurance. Current options focus on "surcharges" placed upon health services, premiums or claims to generate funds that subsidize premiums.

Surcharges that are placed on hospitals in ways that yield federal matches are an efficient mechanism for generating funds at the State level, though care must be used to assure that distortions in hospital costs don't get out of control.

Surcharges on premiums or claims are the mechanism that leads to my main message here today: BE CAREFUL. What, I talk for 10 minutes and what I say is "be careful"?

TANSTAAFL. There ain't no such thing as a free lunch. Surcharges will be passed on in the form of premium increases. If the 700,000 persons in the small group market and the 350,000 persons in the current individual market face a 1.8% additional increase in prices (for MI-Health, I think), would likely translate into 12 thousand persons dropping health insurance coverage [with a demand price elasticity of -0.60]. Will the funds generated by this portion of the subsidy yield more than 12 thousand new enrollees? There may be scenarios where this results in a larger number of insured persons, but be careful.

A BRIEF REPORT BY THE Dartmouth Atlas

Hospital referral region State Inflation-adjusted total Medicare spending per enrollee

Area	1992	2006	Annual Growth Rate
Ann Arbor	5,543	9,002	3.52%
Dearborn	5,878	10,689	4.36%
Detroit	6,016	10,081	3.76%
Flint	6,114	9,100	2.88%
Grand Rapids	3,857	7,380	4.74%
Kalamazoo	4,365	8,008	4.43%
Lansing	4,585	8,186	4.23%
Marquette	3,891	6,106	3.27%
Muskegon	3,930	7,660	4.88%
Petoskey	4,417	6,973	3.32%
Pontiac	6,496	9,444	2.71%
Royal Oak	5,946	10,161	3.90%
Saginaw	4,680	8,572	4.42%
St. Joseph	4,031	7,577	4.61%
Traverse City	4,064	6,611	3.54%

http://www.dartmouthatlas.org/atlas/Policy_Implications_Brief_022709.pdf

Committee Health Policy

Location Senate Hearing Room, Ground Floor, Boji Tower, 124 W. Allegan Street, Lansing, MI 48933

Date Wednesday, 11/7/2007

Time 3:00 PM

Agenda Testimony Only:

SB 579 (George) Insurance; health; MI-Health act; create.

SB 580 (Pappageorge) Insurance; health; individual health benefit plans; regulate.

SB 581 (Jansen) Insurance; health care corporations; nongroup coverage and certain fees; require to comply with insurance code and provide for general amendments.

SB 582 (Jelinek) Health facilities; quality assurance assessments; amount collected from hospitals; increase to maximum allowed for federal matching requirements, and allow subsidization of MI-Health program.

Chair Thomas George